Claims

We claim:

1. In a general purpose computer system comprising:

a central processing unit,

dynamic memory,

static memory,

a display device,

an input device,

an output device

a mass storage device which contains

a number of historical medical provider patient billing records identifiable as patient records,

a grouping of diagnosis codes,

a grouping of qualifying circumstance codes,

a grouping of staging indicators,

a grouping of preventive codes,

a grouping of complication codes,

a method for generating a medical provider profile comprising the steps of:

(a) selecting a diagnosis code,

(b) reading a plurality of patient records from the mass storage device into the dynamic memory, each of said patient records having said selected diagnosis code and

all of said patient records read corresponding to a single patient,

(c) comparing each of said read patient records with each qualifying circumstance code in the grouping of qualifying circumstance codes,

(d) re-sorting each of said patient records having a qualifying circumstance,

(e) reading a staging indicator corresponding to said selected diagnosis code into dynamic memory,

(f) creating a grouping of said selected diagnosis code with each code in the grouping of related diagnoses codes which correspond to said selected diagnosis code thereby creating a grouping of related codes,

(g) searching said plurality of read patient records for the record containing the earliest date on which said selected diagnosis code occurs and noting said date as a first occurrence date,

(h) for each read patient record corresponding to a code in said grouping of related codes, rejecting said read patient record if a comparison of each of said read patient records with said staging indicator and said first occurrence date shows that for any read patient record, the date of a read patient record predates said first occurrence date by a period of time that exceeds said staging indicator,

(i) for each read patient record corresponding to a code in said grouping of related codes, rejecting said

read patient record if a comparison of each of said read patient record with said staging indicator and said first occurrence date shows that for any read patient record, the date of a read patient record postdates said first occurrence date by a period of time that exceeds said staging indicator,

(j) for each read patient record not rejected in steps (a) through (i) above, rejecting said record if said selected diagnosis code does not appear on at least two separate dates on said record,

(k) for each read patient record not rejected in steps (a) through (j) above, writing said record into a parameter table to create a profile for said selected diagnosis.

2. In a general purpose computer system comprising:

a central processing unit,

dynamic memory,

static memory,

a display device,

an input device,

an output device

a mass storage device which contains

a grouping of medical provider profiles,

a method for utilizing a medical provider profile comprising the steps of:

(a) selecting a medical provider profile having a plurality of parameters,

(b) receiving a medical claim that includes a diagnosis and

(c) comparing said medical claim diagnosis to said medical provider profile to determine whether said medical claims falls within the parameters of said profile.

3. A system for establishing medical provider profiles, the system comprising:

(a) means for receiving a quantity of historical medical provider patient billing records identifiable as patient records,

(b) a grouping of diagnosis codes,

(c) a grouping of qualifying circumstances,

(d) a grouping of staging indicators,

(e) a grouping of preventive codes,

(f) a grouping of complication codes,

(g) means for selecting a diagnosis code,

(h) means for organizing a grouping of patient records, each of said organized patient records having a selected diagnosis code and all of said organized patient records corresponding to a single patient,

(i) means for comparing each of said organized patient records with each qualifying circumstance,

(j) means for rejecting each of said patient records having a qualifying circumstance,

(k) means for reading a staging indicator corresponding to said selected diagnosis code into dynamic memory,

(l) means for creating a grouping of said selected diagnosis code with each code in a grouping of qualifying circumstance codes which corresponds to said selected diagnosis code thereby creating a grouping of related codes,

(m) means for searching said plurality of read patient records for the record containing the earliest date on which said selected diagnosis code occurs and noting said date as a first occurrence date,

(n) for each read patient record corresponding to a code in said grouping of related codes, means for rejecting said read patient record if a comparison of each of said read patient records with said staging indicator and said first occurrence date shows that for any read patient record, the date of a read patient record predates said first occurrence date by a period of time that exceeds said staging indicator,

(o) for each read patient record corresponding to a code in said grouping of related codes, means for rejecting said read patient record if a comparison of each of said read patient record with said staging indicator and said first occurrence date shows that for any read patient record, the date of a read patient record postdates said

first occurrence date by a period of time that exceeds said staging indicator,

(p) for each read patient record not rejected in steps (a) through (o) above, means for rejecting said record if said selected diagnosis code does not appear on at least two separate dates on said record,

(q) for each read patient record not rejected in steps (a) through (p) above, means for writing said record into a parameter table to create a profile for said selected diagnosis.

4. In a general purpose computer system comprising:

a central processing unit,

dynamic memory, and

a mass storage device,

a method for establishing a medical provider profile comprising the steps of:

(a) receiving a number of medical provider billing records,

(b) selecting a general diagnosis code,

(c) selecting a patient record that contains said diagnosis code from said medical provider billing records,

(d) comparing said patient record with a qualifying circumstance table and rejecting said patient record if it contains a qualifying circumstance code,

(e) selecting from a table containing specific diagnosis codes all specific diagnosis codes related to said general diagnosis code,

(f) selecting from a table containing preventive codes all preventive codes related to said general diagnosis code,

(g) selecting from a table containing aftermath codes all aftermath codes related to said general diagnosis code,

(h) grouping said general diagnosis code, said selected specific diagnosis codes, said selected preventive diagnosis codes, and said selected aftermath codes into a group of related codes,

(i) assigning said patient record with a staging indicator associated with said general diagnosis code,

(j) determining a first occurrence of said general diagnosis code in said patient record,

(k) rejecting said patient record if a comparison of the date of each occurrence of a code in said group of related codes with said first occurrence date shows that an occurrence of a code in said group of related codes has a date that predates the first occurrence date by more than a period of time indicated by said staging indicator,

(l) rejecting said patient record if a comparison of the date of each occurrence of a code in said group of related codes with said first occurrence date shows that an occurrence of a code in said group of related codes has a

date that postdates the first occurrence date by more than a period of time indicated by said staging indicator,

(m) rejecting said patient record if said diagnosis code appears in said patient record on no more than a single date,

(n) if said patient record has not been rejected, entering it into a parameter database.

5. A method for analyzing a healthcare provider billing patterns comprising the steps of:

(a) obtaining a base data set of medical provider billing information,

(b) verifying base data contained in said base data set, said verifying step including identifying the existence of errors in said base data,

(c) correcting errors identified during said verifying step,

(d) obtaining a healthcare provider billing data set,

(e) comparing said healthcare provider billing data with said base data, and

(f) generating a report which describes a relationship between said healthcare provider billing data and said base data.

6. A method as recited in claim 5, wherein said step of obtaining a base data set of medical provider billing information further comprises:

(i) obtaining an existing data set comprising:

national profiles and

regional profiles,

(ii) building a base data set comprising patient records comprising:

line items,

identifying codes for reporting medical services,

Index codes,

Dates of Service, and

Service Name,

(iii) determining a patient record from said base data set of patient records for an episode of care extraction process, and

(iv) manipulating said patient record to extrapolate desired information.

7. A method as recited in claim 5 wherein said base data contained in said base data set comprises:

(i) a claims history that includes a plurality of line items,

(ii) a plurality of description tables of data that include

(1) a Identifying code for reporting a medical service description table,

(2) a description table, and

(3) an disease classification description table,

(iii) checking said line items against said Identifying code for reporting a medical service description table,

(iv) checking said line items against said description table,

(v) checking said line items against said disease classification description table,

(vi) counting invalid line items,

(vii) checking said line items against date of service, said checking step comprising:

(1) expanding into separate line items any said line items which contain "date of service from" and a "data of service to" where the said two dates are not the same,

(2) dating said services with a unique date of service beginning with said "date of service from" for first said line item and ending with said "date of service to" for last said line item, and

(viii) converting Identifying code for reporting a medical service code formats to standard identifying code for reporting a medical service code format.

8. A method as recited in claim 5, wherein said step of correcting errors identified further comprises:

(a) detecting a duplicate line item among said line items,

(b) editing said claims history line items,

(c) detecting a inappropriately billed service among said services, and

(d) editing said inappropriately billed service.

9. A method as recited in claim 5, wherein said step of comparing said healthcare provider billing data with said base data further comprises:

(a) performing a data history search producing an information set,

(b) accessing a plurality of parameter tables, said parameter table comprising

(i) index codes, and

(ii) statistical criteria,

(c) comparing said information set against said index codes,

(d) checking if said information set falls within a defined statistical criteria,

(e) setting an indication if said information set falls within said defined statistical criteria, and

(f) providing a variance alert describing differences between said information set and said defined statistical criteria.

10. A method as recited in claim 5, wherein said step of generating a report which describes a relationship between said healthcare provider billing data and said base data further comprises:

(a) producing a comparison report comprising:

(i) a plurality of healthcare provider's utilization of Identifying code for reporting a medical service codes,

(ii) a reference set of utilization profiles,

(iii) a plurality of healthcare provider's utilization of disease classification codes,

(iv) a first comparison summary of said healthcare provider's utilization of Identifying code for reporting a medical service codes against said reference set of utilization profiles, said first comparison summary comprising

(a) the number of said services,

(b) the frequency of said services,

(c) the chronological order of said services, and

(d) statistical information on said services, comprising:

(1) the range,

(2) the mode, and

(3) the confidence interval,

(v) a second comparison summary of said healthcare provider's utilization of disease classification codes against said reference set of utilization profiles, said second comparison summary comprising

(a) the number of said services,

(b) the frequency of said services,

(c) the chronological order of said services, and

(d) statistical information on said services, comprising:

(1) the range,

(2) the mode, and

(3) the confidence interval,

(b) producing a provider practice profile report comprising:

(i) a summary of total Identifying code for reporting a medical service utilization by said healthcare provider during a specified time interval to provide a comparison against said reference data, and

(ii) a summary of total disease classification code utilization by said healthcare provider during a specified time interval to provide a comparison against said reference data.

11. A method for analyzing a healthcare provider billing patterns comprising the steps of:

(a) obtaining a base data set of medical provider billing information,

(b) verifying base data contained in said base data set, said verifying step including identifying errors in said base data,

(c) correcting errors identified during said verifying step,

(d) establishing an episode of care for a particular medical event,

(e) obtaining a healthcare provider billing data set,

(f) comparing said healthcare provider billing data with said base data,

(g) reviewing a patient medical history record contained within said healthcare provider billing data set for the presence of a specific medical procedure, and

(h) generating a report which describes a relationship between said healthcare provider billing data and said base data.

12. A method as recited in claim 11,

wherein said step of obtaining a base data set of medical provider billing information further comprises:

(i) obtaining a commercially available data set comprising:

national profiles, and

regional profiles,

(ii) building base data set comprising patient records comprising:

line items,

Identifying code for reporting a medical service codes,

Index codes,

Dates of Service, and

Service Name,

(iii) determining a patient record from said base data set of patient records for an episode of care extraction process, and

(iv) manipulating said patient record to extrapolate pertinent information to conform with procedure logic.

13. A method as recited in claim 11

wherein said step of verifying base data contained in said base data set, further comprises:

(i) obtaining a claims history, said claims history comprising a plurality of line items,

(ii) accessing a plurality of description tables of data, aid description tables comprising:

(1) a table of Identifying codes for reporting a medical service description,

(2) a description table, and

(3) a disease classification description table,

(iii) checking said line items against said Identifying code for reporting a medical service description table to determine whether said line item is valid,

(iv) checking said line items against said description table to determine whether said line item is valid,

(v) checking said line items against said disease classification description table to determine whether said line item is valid,

(vi) counting invalid line items,

(vii) checking said line items against date of service, said date of service checking comprising:

(1) expanding into separate line items any said line items which contain "date of service from" and a "data of service to" where the said two dates are not the same,

(2) dating said services with a unique date of service beginning with said "date of service from" for first said line item and ending with said "date of service to" for last said line item, and

(viii) converting Identifying code for reporting a medical service code formats to standard Identifying code for reporting a medical service code format.

14. A method as recited in claim 11, wherein said step of correcting identified errors further comprises:

(a) detecting a duplicate line item among said line items,

(b) editing said claims history line items,

(c) detecting a inappropriately billed service among said services, and

(d) editing said inappropriately billed services.

15. A method as recited in claim 11, wherein said step of comparing said healthcare provider billing data with said base data further comprises:

(a) performing a data history search to produce an information set,

(b) accessing a plurality of parameter tables comprising

(i) index codes, and

(ii) statistical criteria,

(c) comparing said information set against said index codes,

(d) checking if said information set falls within a defined statistical criteria,

(e) setting an indication if said information set falls within said defined statistical criteria, and

(f) providing a variance alert describing differences between said information set and said defined statistical criteria.

16. A method as recited in claim 11, wherein said step of generating a report which describes a relationship between said healthcare provider billing data and said base data further comprises:

(a) producing a comparison report comprising:

(i) a plurality of healthcare provider's utilization of Identifying code for reporting a medical service codes,

(ii) a reference set of utilization profiles,

(iii) a plurality of healthcare provider's utilization of disease classification codes,

(iv) a comparison of said healthcare provider's utilization of Identifying code for reporting a medical service codes against said reference set of utilization profiles, comprising:

(A) number of said services,

(B) frequency of said services,

(C) chronological order of said services, and

(D) statistical information on said services, comprising:

(1) range,

(2) mode, and

(3) confidence interval,

(v) a comparison of said healthcare provider's utilization of disease classification codes against said reference set of utilization profiles, comprising:

(A) number of said services,

(B) frequency of said services,

(C) chronological order of said services, and

(D) statistical information on said services, comprising:

(1) range,

(2) mode, and

(3) confidence interval,

(b) producing a provider practice profile report comprising:

(i) a summary of total Identifying code for reporting a medical service utilization by said healthcare provider during a specified time interval to provide a comparison against said reference data, and

(ii) a summary of total disease classification code utilization by said healthcare provider during a specified time interval to provide a comparison against said reference data.

17. A method as recited in claim 11, wherein said step of establishing an episode of care for a particular medical event further comprises:

(a) identifying a plurality of medical conditions that require a specific category procedure during a course of treatment,

(b) identifying a plurality of medical conditions that have a qualifying circumstance,

(c) identifying a plurality of interrelational index tables,

(d) designating a particular index code,

(e) identifying a patient record with said index code on at least two said dates of service,

(f) rejecting patient records with less than two occurrences of said particular index code,

(g) searching said patient record for at least one occurrence of the said specific category procedure in said patient record,

(h) searching said patient record for at least one occurrence of an qualifying circumstance,

(i) checking said patient records against said Index Tables, to identify disease classification codes associated with an index code,

(j) creating a temporary file based on combining said disease classification codes that are associated with a given said index code,

(k) checking a patient record identified as containing a selected index code to find the first occurrence of said index code,

(l) searching through said patient record backward in time starting with said first occurrence of said index code for a clear window,

(m) searching through said patient record forward in time starting with said first occurrence of said index code for a clear window,

(n) rejecting said patient record if no clear window is found,

(o) establishing an Episode of Care if both said backward clear window and said forward clear windows are found,

(p) accessing a plurality of medical treatment patterns,

(q) sorting said base data set information from said patient records by plurality of treatment patterns,

(r) accessing a plurality of parameter tables,

(s) populating said parameter tables with said base data from all said episodes of care for each said index code to provide summary statistics, and

(t) sorting said parameter tables information chronologically, category and by said profile classes.

18. A method as recited in claim 11, wherein said step of reviewing a patient medical history record further comprises:

(a) accessing a plurality of parameter tables,

(b) choosing a disease classification description for review,

(c) accessing a disease classification description table,

(d) accessing said disease classification description table to verify said diagnosis code is valid,

(e) accessing said disease classification description table to verify said diagnosis code is an Index code,

(f) prompting for a search for said selected disease classification code to list what index codes it may be associated with, if said chosen diagnosis is not listed as an Index code,

(g) conducting a word search for the said diagnosis to the said disease classification codes in said Index code,

(h) accessing said parameter tables to display selected profiles,

(i) choosing said profiles from one of said data sets, and

(j) accessing procedure description table and category table to ascertain procedure description codes.

19. A method for analyzing a healthcare provider's billing patterns comprising the steps of:

(a) obtaining a base data set of medical provider billing information,

(b) verifying base data contained in said base data set, said verifying step including identifying errors in said base data,

(c) correcting errors identified during said verifying step,

(d) establishing an episode of care for a particular medical event,

(e) screening said base data set for medical records within an episode of care,

(f) obtaining a healthcare provider billing data set,

(g) comparing said healthcare provider billing data with said base data,

(h) reviewing a patient medical history record contained within said healthcare provider billing data set for the presence of a specific medical procedure, and

(i) generating a report which describes a relationship between said healthcare provider billing data and said base data.

20. A method as recited in claim 19,

wherein said step of obtaining a base data set of medical provider billing information further comprises:

(i) obtaining a commercially available data set comprising:

national profiles, and

regional profiles,

(ii) building base data set comprising patient records comprising:

line items,

Identifying code for reporting a medical service codes,

Index codes,

Dates of Service, and

Service Name,

(iii) determining a patient record from said base data set of patient records for an episode of care extraction process, and

(iv) manipulating said patient record to extrapolate pertinent information to conform with procedure logic.

21. A method as recited in claim 19

wherein said step of verifying base data contained in said base data set, further comprises:

(i) obtaining a claims history, said claims history comprising a plurality of line items,

(ii) accessing a plurality of description tables of data, said description tables comprising:

(1) a Identifying code for reporting a medical service description table,

(2) a procedure description table, and

(3) an disease classification description table,

(iii) checking said line items against said Identifying code for reporting a medical service description table to determine whether said line item is valid,

(iv) checking said line items against said procedure description table to determine whether said line item is valid,

(v) checking said line items against said disease classification description table to determine whether said line item is valid,

(vi) counting invalid line items,

(vii) checking said line items against date of service, comprising:

(1) expanding into separate line items any said line items which contain "date of service from" and a "data of service to" where the said two dates are not the same,

(2) dating said services with a unique date of service beginning with said "date of service from" for first said line item and ending with said "date of service to" for last said line item, and

(viii) converting Identifying code for reporting a medical service code formats to standard Identifying code for reporting a medical service code format.

22. A method as recited in claim 19, wherein said step of correcting errors identified further comprises:

(a) detecting any possible duplicate line items among said line items,

(b) editing said claims history line items,

(c) detecting any possible inappropriately billed services among said services, and

(d) editing said inappropriately billed services.

23. A method as recited in claim 19, wherein said step of comparing said healthcare provider billing data with said base data further comprises:

(a) performing a data history search to produce an information set,

(b) accessing a plurality of parameter tables comprising

(i) index codes, and

(ii) statistical criteria,

(c) comparing said information set against said index codes,

(d) checking if said information set falls within a defined statistical criteria,

(e) setting an indicator if said information set falls within said defined statistical criteria, and

(f) providing a variance alert describing differences between said information set and said defined statistical criteria.

24. A method as recited in claim 19, wherein said step of generating a report which describes a relationship between said healthcare provider billing data and said base data further comprises:

(a) generating a comparison report comprising:

(i) a plurality of healthcare provider's utilization of Identifying code for reporting a medical service codes,

(ii) a reference set of utilization profiles,

(iii) a plurality of healthcare provider's utilization of disease classification codes,

(iv) a comparison of said healthcare provider's utilization of Identifying code for reporting a medical service codes against said reference set of utilization profiles, comprising

(A) number of said services,

(B) frequency of said services,

(C) chronological order of said services, and

(D) statistical information on said services, comprising:

(1) range,

(2) mode, and

(3) confidence interval,

(v) a comparison of said healthcare provider's utilization of disease classification codes against said reference set of utilization profiles, comprising

(A) number of said services,

(B) frequency of said services,

(C) chronological order of said services, and

(D) statistical information on said services, comprising:

(1) range,

(2) mode, and

(3) confidence interval,

(b) generating a provider practice profile report comprising:

(i) a summary of total Identifying code for reporting a medical service utilization by said healthcare provider during a specified time interval to provide a comparison against said reference data, and

(ii) a summary of total disease classification code utilization by said healthcare provider during a specified time interval to provide a comparison against said reference data.

25. A method as recited in claim 19, wherein said step of establishing an episode of care for a particular medical event further comprises:

(a) determining a plurality of medical conditions that require a specific category procedure during the course of treatment,

(b) determining a plurality of medical conditions that have a Qualifying Circumstance,

(c) accessing a plurality of interrelational index tables,

(d) designating a particular index code,

(e) identifying a patient record with a particular index code on at least two said dates of service,

(f) rejecting patient records with less than two occurrences of the particular index code,

(g) searching said patient record for at least one occurrence of the a specific category procedure in said patient record,

(h) searching said patient record for at least one occurrence of a Qualifying Circumstance,

(i) checking said patient record against said Index Tables, to identify disease classification codes associated with the chosen said index code,

(j) creating a temporary file based on combining said disease classification codes that are associated with a given said index code,

(k) checking a patient record that has a selected said index code to find the first occurrence of said index code,

(l) searching through said patient record backward in time starting with said first occurrence of said index code for a clear window,

(m) searching through said patient record forward in time starting with said first occurrence of said index code for a clear window,

(n) rejecting said patient records if no clear window is found,

(o) establishing an Episode of Care if both said backward clear window and said forward clear windows are found,

(p) identifying a plurality of medical treatment patterns,

(q) sorting said base data set information from said patient records by plurality of treatment patterns,

(r) accessing a plurality of parameter tables,

(s) populating said parameter tables with said base data from all said episodes of care for each said index code to provide summary statistics, and

(t) sorting said parameter tables information chronologically, category and by said profile classes.

26. A method as recited in claim 19, wherein said step of reviewing a patient medical history record further comprises:

(a) accessing a plurality of parameter tables,

(b) choosing a disease classification code for review,

(c) accessing said disease classification description table to verify said diagnosis code is valid,

(d) accessing said disease classification description table to verify said diagnosis code is an Index code,

(e) prompting for a search for said selected disease classification code to list what index codes it may be associated with, if said chosen diagnosis is not listed as an Index code,

(f) conducting a word search for the said diagnosis to the said disease classification codes in said Index code,

(g) accessing said parameter tables to display selected profiles,

(h) choosing source of said profiles from either said commercially available data set or said base data set, and

(i) accessing procedure description table and category table to ascertain description of procedure codes.

27. A method as recited in claim 19, wherein said step of screening said base data set for medical records further comprises:

(a) accessing a age/gender table,

(b) accessing a region statistic table,

(c) accessing a Zip/Region table,

(d) accessing a Identifying code for reporting a medical service statistic table,

(e) accessing a specialty table,

(f) selecting said reference profiles,

(g) accessing said age/gender table to determine standard age ranges and/or gender selection for said selected profile,

(h) accessing said region statistic table to determine adjustments due to particular geographic regions for said selected profile,

(i) accessing said Zip/Region table to identify what region a particular geographic zip code falls within,

(j) accessing said Identifying code for reporting a medical service Statistic table to identify what adjustments due to a particular medical specialty, and

(k) accessing said Specialty table to determine what particular specialty groupings are suggested.

28. A method for analyzing a healthcare provider's billing patterns comprising the steps of:

(a) obtaining a base data set of medical provider billing information,

(b) verifying base data contained in said base data set, said verifying step including identifying the existence of errors in said base data,

(c) correcting errors identified during said verifying step,

(d) establishing an episode of care for a particular medical event,

(e) accessing and reviewing said medical record database, said accessing and reviewing comprising the steps of:

(i) establishing a plurality of criteria for searching parameters,

(ii) indexing said records in such a way as they are relationally related to each other, and

(iii) providing a format for the review of the accessed records,

(f) screening said base data set for medical records within an episode of care,

(g) obtaining a healthcare provider billing data set,

(h) comparing said healthcare provider billing data with said base data,

(i) reviewing a patient medical history record contained within said healthcare provider billing data set for the presence of a specific medical procedure, and

(j) generating a report which describes a relationship between said healthcare provider billing data and said base data.

29. A method as recited in claim 28,

wherein said step of obtaining a base data set of medical provider billing information further comprises:

(i) obtaining a commercially available data set comprising:

national profiles, and

regional profiles,

(ii) building base data set comprising patient records comprising:

line items,

Identifying code for reporting a medical service codes,

Index codes,

Dates of Service, and

Service Name,

(iii) determining a patient record from said base data set of patient records for an episode of care extraction process, and

(iv) manipulating said patient record to extrapolate pertinent information to conform with procedure logic.

30. A method as recited in claim 28

wherein said step of verifying base data contained in said base data set, further comprises:

(i) accessing a claims history comprising a plurality of line items,

(ii) accessing a plurality of description tables comprising:

(1) a Identifying code for reporting a medical service description table, and

(2) an disease classification description table,

(iii) checking said line items against said Identifying code for reporting a medical service description table to determine whether said line item is valid,

(iv) checking said line items against said disease classification description table to determine whether said line item is valid,

(v) counting invalid line items,

(vii) checking said line items against date of service, comprising:

(1) expanding into separate line items any said line items which contain "date of service from" and a "data of service to" where the said two dates are not the same,

(2) dating said services with a unique date of service beginning with said "date of service from" for first said line item and ending with said "date of service to" for last said line item, and

(viii) converting Identifying code for reporting a medical service code formats to standard Identifying code for reporting a medical service code format.

31. A method as recited in claim 28, wherein said step of correcting errors identified further comprises:

(a) detecting possible duplicate line items among said line items,

(b) editing said claims history line items,

(c) detecting possible inappropriately billed services among said services, and

(d) editing said inappropriately billed services.

32. A method as recited in claim 28, wherein said step of comparing said healthcare provider billing data with said base data further comprises:

(a) performing a data history search and producing an information set therefrom,

(b) accessing a plurality of parameter tables comprising

(i) index codes, and

(ii) statistical criteria,

(c) comparing said information set against said index codes,

(d) checking if said information set falls within a defined statistical criteria,

(e) setting an indication if said information set falls within said defined statistical criteria, and

(f) providing a variance alert describing differences between said information set and said defined statistical criteria.

33. A method as recited in claim 28, wherein said step of generating a report which describes a relationship between said

healthcare provider billing data and said base data further comprises:

(a) compiling a comparison report comprising:

(i) a plurality of healthcare provider's utilization of Identifying code for reporting a medical service codes,

(ii) a reference set of utilization profiles,

(iii) a plurality of healthcare provider's utilization of disease classification codes,

(iv) a comparison of said healthcare provider's utilization of Identifying code for reporting a medical service codes against said reference set of utilization profiles, comprising

(A) number of said services,

(B) frequency of said services,

(C) chronological order of said services, and

(D) statistical information on said services, comprising:

(1) range,

(2) mode, and

(3) confidence interval,

(v) a comparison of said healthcare provider's utilization of disease classification codes against said reference set of utilization profiles, comprising

(A) number of said services,

(B) frequency of said services,

(C) chronological order of said services, and

(D) statistical information on said services, comprising:

(1) range,

(2) mode, and

(3) confidence interval,

(b) compiling a provider practice profile report comprising:

(i) a summary of total Identifying code for reporting a medical service utilization by said healthcare provider during a specified time interval to provide a comparison against said reference data, and

(ii) a summary of total disease classification code utilization by said healthcare provider during a specified time interval to provide a comparison against said reference data.

34. A method as recited in claim 28, wherein said step of establishing an episode of care for a particular medical event further comprises:

(a) designating a plurality of medical conditions that require a specific category procedure during the course of treatment,

(b) designating a plurality of medical conditions that have a qualifying circumstance,

(c) accessing a plurality of interrelational index tables,

(d) designating a particular index code,

(e) identifying a patient record with said particular index code on at least two said dates of service,

(f) rejecting patient records with less than two occurrences of said particular index code,

(g) searching an identified patient record for at least one occurrence of the said specific category procedure in said patient record,

(h) searching said identified patient record for at least one occurrence of said qualifying circumstance in said patient record,

(i) checking patient records against said Index Tables, to identify disease classification codes associated with the chosen said index code,

(j) searching patient records for any qualifying circumstance disease classification codes,

(k) creating a temporary file based on combining said disease classification codes that are associated with a given said index code,

(l) checking said patient record, identified as containing selected said index code, over the entire said patient record to find the first occurrence of said index code,

(m) searching through said patient record backward in time starting with said first occurrence of said index code for a clear window,

(n) searching through said patient record forward in time starting with said first occurrence of said index code for a clear window,

(o) rejecting said patient record if no clear window is found,

(p) establishing an Episode of Care if both said backward clear window and said forward clear windows are found,

(q) selecting a plurality of medical treatment patterns,

(r) sorting said base data set information from said patient records by plurality of treatment patterns,

(s) a plurality of parameter tables,

(t) populating said parameter tables with said base data from all said episodes of care for each said index code to provide summary statistics, and

(u) sorting said parameter tables information chronologically, category and by said profile classes.

35. A method as recited in claim 28, wherein said step of reviewing a patient medical history record further comprises:

(a) accessing a plurality of parameter tables,

(b) choosing a disease classification code for review,

(c) accessing a disease classification description table,

(d) accessing said disease classification description table to verify said diagnosis code is valid,

(e) accessing said disease classification description table to verify said diagnosis code is an Index code,

(f) prompting for a search for said selected disease classification code to list what index codes it may be associated with, if said chosen diagnosis is not listed as an Index code,

(g) conducting a word search for the said diagnosis to the said disease classification codes in said Index code,

(h) accessing said parameter tables to display selected profiles,

(i) choosing source of said profiles from either said commercially available data set or said base data set, and

(j) accessing procedure description table and category table to ascertain description of procedure codes.

36. A method as recited in claim 28, wherein said step of screening said base data set for medical records further comprises:

(a) selecting reference profiles,

(b) accessing an age/gender table to determine standard age ranges and/or gender selection for said selected profile,

(c) accessing a region statistic table to determine adjustments due to particular geographic regions for said selected profile,

(d) accessing a Zip/Region table to identify what region a particular geographic zip code falls within,

(e) accessing an Identifying code for reporting a medical service Statistic table to identify what adjustments due to a particular medical specialty, and

(f) accessing a Specialty table to determine what particular specialty groupings are suggested.

37. In a general purpose computer system comprising:

a central processing unit,

dynamic memory,

an input device,

an output device,

a display device, and

a mass storage device,

a method for analyzing a healthcare provider's billing patterns comprising the steps of:

(a) storing a base data set of medical provider billing information on the mass storage device,

(b) storing said healthcare provider's billing information on the mass storage device,

(c) verifying said base data set to be used for comparison, by retrieving said base data set information from mass storage device, storing said base data set information in the dynamic memory, and displaying said base data set information on the display device,

(d) correcting errors discovered during said verification process, by utilizing the input device to edit said displayed base data set information,

(e) comparing said healthcare provider's billings with said comparison data, by retrieving said healthcare provider's billings from the mass storage device and storing in the dynamic memory, retrieving said comparison data from mass storage and storing in the dynamic memory, and performing a text field comparison between the said two sets of data stored in dynamic memory, and storing the result of the said comparison operation into mass storage, and

(f) generating reports for the purpose of describing the relationship between said healthcare provider's billings and comparison data by retrieving said comparison information from mass storage and writing said information to output device.

Add B16